

**TRANSMITTAL AND NOTICE OF APPROVAL OF  
STATE PLAN MATERIAL**

**FOR: HEALTH CARE FINANCING ADMINISTRATION**

1. TRANSMITTAL NUMBER:

0 1 — 0 3 5

2. STATE:

Arkansas

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)

TO: REGIONAL ADMINISTRATOR  
HEALTH CARE FINANCING ADMINISTRATION  
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE

April 1, 2002

5. TYPE OF PLAN MATERIAL (Check One):

☐ NEW STATE PLAN

☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN

☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT (Separate Transmittal for each amendment)

6. FEDERAL STATUTE/REGULATION CITATION:

42 CFR 440.130(d)

7. FEDERAL BUDGET IMPACT:

a. FFY 2002 \$ ( 661,812.00 )  
b. FFY 2003 \$ ( 1,353,508.00 )

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:

Please see attached listing

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT (If Applicable):

Please see attached listing ✕

10. SUBJECT OF AMENDMENT:

The Arkansas Title XIX State Plan has been amended to reflect that prior authorization will be required for outpatient mental health services for recipients under age 21.

11. GOVERNOR'S REVIEW (Check One):

- ☒ GOVERNOR'S OFFICE REPORTED NO COMMENT  
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED  
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL

☐ OTHER, AS SPECIFIED:

12. SIGNATURE OF STATE AGENCY OFFICIAL:

13. TYPED NAME:

Ray Hanley

14. TITLE:

Director, Division of Medical Services

15. DATE SUBMITTED:

November 30, 2001

16. RETURN TO:

Division of Medical Services  
P. O. Box 1437  
Little Rock, AR 72203-1437

Attention: Binnie Alberius  
Slot ~~XXX~~ S295

**FOR REGIONAL OFFICE USE ONLY**

17. DATE RECEIVED:

10 DECEMBER 2001

18. DATE APPROVED:

21 DECEMBER 2001

**PLAN APPROVED - ONE COPY ATTACHED**

19. EFFECTIVE DATE OF APPROVED MATERIAL:

1 APRIL 2002

20. SIGNATURE OF REGIONAL OFFICIAL:

*Trudy Crumley*

21. TYPED NAME:

Calvin G. Cline

22. TITLE:

Associate Regional Administrator  
Division of Medicaid and State Operations

23. REMARKS:

Pen and ink changes per Becky Murphy 12/21/01 E. Williams

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT  
MEDICAL ASSISTANCE PROGRAM  
STATE ARKANSAS

ATTACHMENT 3.1-A  
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AMOUNT, DURATION AND SCOPE OF  
SERVICES PROVIDED

Revised: April 1, 2002

CATEGORICALLY NEEDY

4.b. Early and Periodic Screening and Diagnosis of Individuals Under 21 Years of Age, and Treatment of Conditions Found. (Continued)

(13) Psychology Services

(1) Services are limited to eligible Medicaid recipients in the Child Health Services (EPSDT) Program.

(2) Services must be provided by a licensed psychologist and prescribed by a physician.  
Outpatient Psychology services are as follows:

- a. Diagnosis
- b. Diagnosis - Psychological Test/Evaluation
- c. Diagnosis - Psychological Testing Battery
- d. Interpretation of Diagnosis
- e. Crisis Management Visit
- f. Individual Outpatient - Therapy Session\*
- g. Marital/Family Therapy\*
- h. Individual Outpatient - Collateral Services\*
- i. Group Outpatient - Group Therapy\*

\* Effective April 1, 2002, these services require prior authorization for eligible Medicaid recipients under age 21 to determine and verify the patient's need for services.

SUPERSEDES: TN- 91-59

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| HCFA 179 <u>Ar2-01-35</u>   |   |

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AMOUNT, DURATION AND SCOPE OF  
SERVICES PROVIDED

Revised: April 1, 2002

CATEGORICALLY NEEDY

4b. Early and Periodic Screening and Diagnosis of Individuals Under 21 Years of Age, and Treatment of Conditions Found. (Continued)

18. Rehabilitative Services (continued)

1. School-Based Mental Health Services (continued)

f. Covered Services (continued)

5. Crisis Management Visit - An unscheduled direct service contact between an identified patient and school-based mental health services provider personnel for the purpose of preventing an inappropriate or more restrictive placement.
6. Individual Outpatient\* - Therapy Session - Scheduled individual outpatient care provided by school-based mental health services provider personnel to a patient for the purposes of treatment and remediation of a condition described in DSM-IV and subsequent revisions.
7. Marital/Family Therapy\* - Treatment provided to two or more family members and conducted by school-based mental health services provider personnel. The purpose of this service is the treatment and remediation of the recipient's psychiatric condition and must address marital/family issues that have a direct impact on the symptoms experienced by the recipient.
8. Individual Outpatient\* - Collateral Services - A face to face contact by school-based mental health services provider personnel with other professionals, caregivers or other parties on behalf of an identified patient to obtain relevant information necessary to the patient's assessment, evaluation and treatment.
9. Group Outpatient\* - Group Therapy - A direct service contact between a group of patients and school-based mental health services provider personnel for the purposes of treatment and remediation of a psychiatric condition.

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4b. Early and Periodic Screening and Diagnosis of Individuals Under 21 Years of Age, and Treatment of Conditions Found. (Continued)

19. Rehabilitative Services for Children (Continued)

- (4) A statement of the persons responsible for implementing the plan of care; and
- (5) A statement of the functional outcomes expected to be achieved through the provision of services and supports.

- 2. Therapeutic Foster Care - This residential service is provided to children whose plan of care indicates a need for a structured and consistent home environment in order to learn to manage their behavior. This twenty-four hour service consists of face-to-face interventions with a child to assist the child in understanding the consequences of inappropriate behaviors and adhering to a behavioral routine which minimizes inappropriate behaviors and their consequences. This service is provided for the purpose of the development, restoration, and/or maintenance of the child's mental or emotional growth and the development, restoration, and/or maintenance of the skills to manage his/her mental or emotional condition.
- 3. Residential Treatment - This residential service provides twenty-four hour treatment to children whose psychological or emotional problems related to neglect and/or abuse can best be restored by residential treatment in accordance with the child's plan of care. The objective of this service is to assist the child in improving or maintaining his/her highest functioning level through individual and group therapeutic interventions to improve or maintain the skills needed to safely and securely interact with other persons, through symptom management to allow the child to identify and minimize the negative effects of psychiatric or emotional symptoms which interfere with the child's personal development and community integration, and through supportive counseling with a child to develop, restore and/or maintain the child's mental or emotional growth.

PROVIDER QUALIFICATION

Rehabilitative services for children will be provided only through qualified provider agencies. Qualified provider agencies must meet the following rehabilitative services for children criteria:

- 1. Have full access to all pertinent records concerning the child's needs for services including records of the Arkansas District Courts, local Children's Service Agencies, and State Child and Family Services Agency,

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4b. Early and Periodic Screening and Diagnosis of Individuals Under 21 Years of Age, and Treatment of Conditions Found. (Continued)

20. Rehabilitative Services to Youth (Continued)

2. Therapy - This non-residential service provides for a therapeutic relationship between the client and a "qualified therapist" for the purpose of accomplishing changes that are identified as goals in the case plan through the use of various counseling techniques. Services to specific individuals include:

- (a) Individual therapy,\*
- (b) Group therapy,\*
- (c) Family therapy\* (youth included), and
- (d) Consultation with the referral source.

Qualified therapist is defined as a Master's level professional or Bachelor's level professional supervised by a Master's level clinician, or a Master's level psychologist supervised by a Ph. D. level psychologist who is licensed in the State of Arkansas in either psychology, social work or professional counseling. To be considered as a "Qualified Therapist" the individual must be in good standing before the board to which he or she is licensed.

3. Emergency Shelter - This residential service provides services for youth whose circumstances or behavioral problems necessitate immediate removal from their homes or for youth released from a youth services facility who need temporary placement in the community until long term residential arrangements can be made. Emergency Shelter services include:

- (a) Additional evaluation of the nature and extent of a youth's emotional and behavioral problems, including social assessment psychological evaluation, psychiatric evaluation and consultation with the referring agency, and
- (b) Interventions to address the youth's emotional and behavioral problems.

The extent and depth of services provided to a youth in the Emergency Shelter program depends upon the individual needs of the youth and the referral source.

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4b. Early and Periodic Screening and Diagnosis of Individuals Under 21 Years of Age, and Treatment of Conditions Found. (Continued)

20. Rehabilitative Services to Youth (Continued)

4. Therapeutic Foster Care - This residential service provides intensive therapeutic care for children provided in family homes which operate within a comprehensive residential treatment system or as an adjunct to a mental health treatment program and for which a service fee is paid to specially trained foster families. Care givers who provide this service in their homes, if not specially trained, are specifically qualified to provide the service because they have an educational or a professional background that attests to qualification equal to or greater than that of care givers who have received special training. Children to whom this service is provided have physical, emotional, or behavioral problems which cannot be remedied in their own home, in a routine foster parenting situation, or in a residential program.
5. Therapeutic Group Home - This residential service provides twenty-four hour intensive therapeutic care provided in a small group home setting for youth with emotional and/or behavior problems which cannot be remedied by less intensive treatment, as diagnosed by a qualified professional. The program is offered to prepare a juvenile for less intensive treatment, independent living, or to return to the community.
6. Residential Treatment - This residential service provides twenty-four hour treatment service available for up to one year for each individual, for youth whose emotional and/or behavioral problems, as diagnosed by a qualified professional, cannot be remedied in his or her own home. Residential Treatment services require the formulation and implementation of an individualized treatment plan with time-framed, measurable objectives for each youth.

Qualified professional is defined as a Master's level professional or Bachelor's level professional supervised by a Master's level clinician, or a Master's level psychologist supervised by a Ph. D. level psychologist who is licensed in the State of Arkansas in either psychology, social work or professional counseling. To be considered as a "Qualified Professional" the individual must be in good standing before the board to which he or she is licensed.

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CATEGORICALLY NEEDY

4b. Early and Periodic Screening and Diagnosis of Individuals Under 21 Years of Age, and Treatment of Conditions Found. (Continued)

21. Other Licensed Practitioners

1. Licensed Certified Social Worker (LCSW)

- a. Services are limited to Medicaid eligible recipients under age 21 in the Child Health Services (EPSDT) Program.
- b. Services must be provided by a licensed certified social worker (LCSW) who has a Master's degree in social work from a graduate school of social work accredited by the Council on Social Work Education (CSWE). The LCSW must be State licensed and certified to practice as a Licensed Certified Social Worker (LCSW) in the State of Arkansas and in good standing with the Arkansas Social Work Licensing Board.
- c. A referral must be made by a Medicaid enrolled physician documenting services are medically necessary. Covered outpatient LCSW services are:
  1. Diagnosis
  2. Interpretation of Diagnosis
  3. Crisis Management Visit
  4. Individual Outpatient - Therapy Session\*
  5. Marital/Family Therapy\*
  6. Individual Outpatient - Collateral Services\*
  7. Group Outpatient - Group Therapy\*

2. Licensed Professional Counselors (LPC)

- a. Services are limited to Medicaid eligible recipients under age 21 in the Child Health Services (EPSDT) Program.
- b. Services must be provided by a licensed professional counselor (LPC) who must possess a Master's degree in mental health counseling from an accredited college or university. The LPC must be licensed as a Licensed Professional Counselor and be in good standing with the Arkansas Board of Examiners in Counseling.
- c. A referral must be made by a Medicaid enrolled physician documenting medical necessity. Covered outpatient LPC services are:
  1. Diagnosis
  2. Interpretation of Diagnosis
  3. Crisis Management Visit
  4. Individual Outpatient - Therapy Session\*
  5. Marital/Family Therapy\*
  6. Individual Outpatient - Collateral Services\*
  7. Group Outpatient - Group Therapy\*

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SUPERSEDES: TN- CO-06

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4b. Early and Periodic Screening and Diagnosis of Individuals Under 21 Years of Age, and Treatment of Conditions Found. (Continued)

21. Other Licensed Practitioners (Continued)

3. Licensed Marriage and Family Therapist (LMFT)

- a. Services are limited to Medicaid eligible recipients under age 21 in the Child Health Services (EPSDT) Program.
- b. Services must be provided by a licensed marriage and family therapist (LMFT) who must possess a Master's degree in mental health counseling from an accredited college or university. The LMFT must be licensed as a Licensed Marriage and Family Therapist and in good standing with the Arkansas Board of Examiners in Counseling.
- c. A referral must be made by a Medicaid enrolled physician documenting services are medically necessary. Covered outpatient LMFT services are:
  1. Diagnosis
  2. Interpretation of Diagnosis
  3. Crisis Management Visit
  4. Individual Outpatient - Therapy Session\*
  5. Marital/Family Therapy\*
  6. Individual Outpatient - Collateral Services\*
  7. Group Outpatient - Group Therapy\*

22. Medical Supplies

1. MIC-KEY Skin Level Gastrostomy Tube and Supplies

Effective for dates of service on or after September 1, 2000 MIC-KEY Skin Level Gastrostomy Tube and Supplies are covered for Medicaid eligible recipients under age 21. Services require prior authorization. The MIC-KEY kit is limited to two (2) per State Fiscal Year. Benefit extensions will be considered on a case by case basis based on medical necessity.

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CATEGORICALLY NEEDY

13. Other diagnostic, screening, preventive and rehabilitative services, i.e., other than those provided elsewhere in this plan. (Continued)
- b. Screening services - Not Provided.
- c. Preventive services - Not Provided.
- d. Rehabilitative Services
1. Rehabilitative Services for Persons with Mental Illness (RSPMI)
- a. Acute Outpatient Services
- Diagnosis
  - Diagnosis - Psychological Test/Evaluation
  - Diagnosis - Psychological Testing Battery
  - Treatment Plan
  - Interpretation of Diagnosis
  - Diagnosis - Speech Evaluation
  - Individual Outpatient - Therapy Session <sup>2,3</sup>
  - Marital/Family Therapy <sup>3</sup>
  - Individual Outpatient - Speech Therapy <sup>1</sup>
  - Group Outpatient - Group Therapy <sup>2,3</sup>
  - Group Outpatient - Medication Maintenance
  - Group Outpatient - Speech Therapy <sup>1</sup>
- <sup>1</sup> Effective for dates of service on or after October 1, 1999, individual and group therapy are limited to four (4) units per day. One unit equals 15 minutes. Evaluations are limited to four (4) units per State Fiscal Year (July 1 through June 30). One unit equals 30 minutes. Extensions of the benefit limits will be provided if medically necessary for eligible Medicaid recipients under age 21.
- <sup>2</sup> Effective April 1, 2000, these services require prior authorization for eligible Medicaid recipients age 21 and over to determine and verify the patient's need for services.
- <sup>3</sup> Effective April 1, 2002, these services require prior authorization for eligible Medicaid recipients under age 21 to determine and verify the patient's need for services.

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13. Other diagnostic, screening, preventive and rehabilitative services, i.e., other than those provided elsewhere in this plan. (Continued)

d. Rehabilitative Services (Continued)

1. Rehabilitative Services for Persons with Mental Illness (RSPMI) - (Continued)

b. Acute Day Treatment <sup>1</sup>

c. Restricted RSPMI Services

- Assessment-Reassessment and Plan of Care
- Crisis Stabilization Intervention <sup>1</sup>
- On-Site Intervention <sup>1,2</sup>
- Off-Site Intervention <sup>1,2</sup>
- Rehabilitation Day Services <sup>1,2</sup>

d. Other RSPMI Services

- Crisis Intervention
- Physical Examination
- Medication Maintenance by a Physician <sup>1</sup>
- Periodic Review of Plan of Care
- Routine Venipuncture for Collection of Specimen
- Catheterization for Collection of Specimen
- Collateral Intervention <sup>2</sup>
- Inpatient Visits in Acute Care Hospitals by Board Certified Psychiatrists

<sup>1</sup> Effective April 1, 2000, these services require prior authorization for eligible Medicaid recipients age 21 and over to determine and verify the patient's need for services.

<sup>2</sup> Effective April 1, 2002, these services require prior authorization for eligible Medicaid recipients under age 21 to determine and verify the patient's need for services.

SUPERSEDES: TN- 01-28

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MEDICALLY NEEDY

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4.b. Early and Periodic Screening and Diagnosis of Individuals Under 21 Years of Age, and Treatment of Conditions Found. (Continued)

(13) Psychology Services

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4b. Early and Periodic Screening and Diagnosis of Individuals Under 21 Years of Age, and Treatment of Conditions Found. (Continued)

18. Rehabilitative Services (continued)

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- (a) Individual therapy,\*
- (b) Group therapy,\*
- (c) Family therapy\* (youth included), and
- (d) Consultation with the referral source.

Qualified therapist is defined as a Master's level professional or Bachelor's level professional supervised by a Master's level clinician, or a Master's level psychologist supervised by a Ph. D. level psychologist who is licensed in the State of Arkansas in either psychology, social work or professional counseling. To be considered as a "Qualified Therapist" the individual must be in good standing before the board to which he or she is licensed.

3. Emergency Shelter - This residential service provides services for youth whose circumstances or behavioral problems necessitate immediate removal from their homes or for youth released from a youth services facility who need temporary placement in the community until long term residential arrangements can be made. Emergency Shelter services include:

- (a) Additional evaluation of the nature and extent of a youth's emotional and behavioral problems, including social assessment psychological evaluation, psychiatric evaluation and consultation with the referring agency, and
- (b) Interventions to address the youth's emotional and behavioral problems.

The extent and depth of services provided to a youth in the Emergency Shelter program depends upon the individual needs of the youth and the referral source.

\* Effective April 1, 2002, these services require prior authorization for eligible Medicaid recipients under age 21 to determine and verify the patient's need for services.

SUPERSEDES: TN- 98-12

|                            |   |
|----------------------------|---|
| STATE <u>Arkansas</u>      | A |
| DATE REC'D <u>12-10-01</u> |   |
| DATE APP'D <u>12-21-01</u> |   |
| DATE EFF <u>04-01-02</u>   |   |
| HCFA 179 <u>Ark-01-35</u>  |   |

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT  
MEDICAL ASSISTANCE PROGRAM  
STATE ARKANSAS

ATTACHMENT 3.1-B  
Page 2vvvv

AMOUNT, DURATION AND SCOPE OF  
SERVICES PROVIDED

Revised: April 1, 2002

MEDICALLY NEEDY

4b. Early and Periodic Screening and Diagnosis of Individuals Under 21 Years of Age, and Treatment of Conditions Found. (Continued)

20. Rehabilitative Services to Youth (Continued)

4. Therapeutic Foster Care - This residential service provides intensive therapeutic care for children provided in family homes which operate within a comprehensive residential treatment system or as an adjunct to a mental health treatment program and for which a service fee is paid to specially trained foster families. Care givers who provide this service in their homes, if not specially trained, are specifically qualified to provide the service because they have an educational or a professional background that attests to qualification equal to or greater than that of care givers who have received special training. Children to whom this service is provided have physical, emotional, or behavioral problems which cannot be remedied in their own home, in a routine foster parenting situation, or in a residential program.
5. Therapeutic Group Home - This residential service provides twenty-four hour intensive therapeutic care provided in a small group home setting for youth with emotional and/or behavior problems which cannot be remedied by less intensive treatment, as diagnosed by a qualified professional. The program is offered to prepare a juvenile for less intensive treatment, independent living, or to return to the community.
6. Residential Treatment - This residential service provides twenty-four hour treatment service available for up to one year for each individual, for youth whose emotional and/or behavioral problems, as diagnosed by a qualified professional, cannot be remedied in his or her own home. Residential Treatment services require the formulation and implementation of an individualized treatment plan with time-framed, measurable objectives for each youth.

Qualified professional is defined as a Master's level professional or Bachelor's level professional supervised by a Master's level clinician, or a Master's level psychologist supervised by a Ph. D. level psychologist who is licensed in the State of Arkansas in either psychology, social work or professional counseling. To be considered as a "Qualified Professional" the individual must be in good standing before the board to which he or she is licensed.

SUPERSEDES TN- 98-12

|                            |   |
|----------------------------|---|
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| DATE REC'D <u>12-10-01</u> |   |
| DATE APP'D <u>12-21-01</u> |   |
| DATE EFF <u>04-01-02</u>   |   |
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ATTACHMENT 3.1-B  
Page 2www

AMOUNT, DURATION AND SCOPE OF  
SERVICES PROVIDED

Revised: April 1, 2002

**MEDICALLY NEEDY**

4b. Early and Periodic Screening and Diagnosis of Individuals Under 21 Years of Age, and Treatment of Conditions Found. (Continued)

21. Other Licensed Practitioners

1. Licensed Certified Social Worker (LCSW)

- a. Services are limited to Medicaid eligible recipients under age 21 in the Child Health Services (EPSDT) Program.
- b. Services must be provided by a licensed certified social worker (LCSW) who has a Master's degree in social work from a graduate school of social work accredited by the Council on Social Work Education (CSWE). The LCSW must be State licensed and certified to practice as a Licensed Certified Social Worker (LCSW) in the State of Arkansas and in good standing with the Arkansas Social Work Licensing Board.
- c. A referral must be made by a Medicaid enrolled physician documenting services are medically necessary. Covered outpatient LCSW services are:
  1. Diagnosis
  2. Interpretation of Diagnosis
  3. Crisis Management Visit
  4. Individual Outpatient - Therapy Session\*
  5. Marital/Family Therapy\*
  6. Individual Outpatient - Collateral Services\*
  7. Group Outpatient - Group Therapy\*

2. Licensed Professional Counselors (LPC)

- a. Services are limited to Medicaid eligible recipients under age 21 in the Child Health Services (EPSDT) Program.
- b. Services must be provided by a licensed professional counselor (LPC) who must possess a Master's degree in mental health counseling from an accredited college or university. The LPC must be licensed as a Licensed Professional Counselor and be in good standing with the Arkansas Board of Examiners in Counseling.
- c. A referral must be made by a Medicaid enrolled physician documenting medical necessity. Covered outpatient LPC services are:
  1. Diagnosis
  2. Interpretation of Diagnosis
  3. Crisis Management Visit
  4. Individual Outpatient - Therapy Session\*
  5. Marital/Family Therapy\*
  6. Individual Outpatient - Collateral Services\*
  7. Group Outpatient - Group Therapy\*

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| DATE EFF. <u>04-01-02</u>   |          |
| HCFA 179 <u>AK-01-35</u>    |          |

\* Effective April 1, 2002, these services require prior authorization for eligible Medicaid recipients under age 21 to determine and verify the patient's need for services.

SUPERSEDES: TN- 01-17

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT  
MEDICAL ASSISTANCE PROGRAM  
STATE ARKANSAS

ATTACHMENT 3.1-B  
Page 2wwwwww

AMOUNT, DURATION AND SCOPE OF  
SERVICES PROVIDED

Revised: April 1, 2002

**MEDICALLY NEEDY**

4b. Early and Periodic Screening and Diagnosis of Individuals Under 21 Years of Age, and Treatment of Conditions Found. (Continued)

21. Other Licensed Practitioners (Continued)

3. Licensed Marriage and Family Therapist (LMFT)

- a. Services are limited to Medicaid eligible recipients under age 21 in the Child Health Services (EPSDT) Program.
- b. Services must be provided by a licensed marriage and family therapist (LMFT) who must possess a Master's degree in mental health counseling from an accredited college or university. The LMFT must be licensed as a Licensed Marriage and Family Therapist and in good standing with the Arkansas Board of Examiners in Counseling.
- c. A referral must be made by a Medicaid enrolled physician documenting services are medically necessary. Covered outpatient LMFT services are:
  1. Diagnosis
  2. Interpretation of Diagnosis
  3. Crisis Management Visit
  4. Individual Outpatient - Therapy Session\*
  5. Marital/Family Therapy\*
  6. Individual Outpatient - Collateral Services\*
  7. Group Outpatient - Group Therapy\*

22. Medical Supplies

1. MIC-KEY Skin Level Gastrostomy Tube and Supplies

Effective for dates of service on or after September 1, 2000 MIC-KEY Skin Level Gastrostomy Tube and Supplies are covered for Medicaid eligible recipients under age 21. Services require prior authorization. The MIC-KEY kit is limited to two (2) per State Fiscal Year. Benefit extensions will be considered on a case by case basis based on medical necessity.

- \* Effective April 1, 2002, these services require prior authorization for eligible Medicaid recipients under age 21 to determine and verify the patient's need for services.

SUPERSEDES: TN- 01-17

|                            |   |
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| STATE <u>Arkansas</u>      | A |
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STATE ARKANSAS

ATTACHMENT 3.1-B  
Page 5d

AMOUNT, DURATION AND SCOPE OF  
SERVICES PROVIDED

Revised: April 1, 2002

MEDICALLY NEEDY

13. Other diagnostic, screening, preventive and rehabilitative services, i.e., other than those provided elsewhere in this plan. (Continued)

b. Screening services - Not Provided.

c. Preventive services - Not Provided.

d. Rehabilitative Services

1. Rehabilitative Services for Persons with Mental Illness (RSPMI)

a. Acute Outpatient Services

- Diagnosis
- Diagnosis - Psychological Test/Evaluation
- Diagnosis - Psychological Testing Battery
- Treatment Plan
- Interpretation of Diagnosis
- Diagnosis - Speech Evaluation
- Individual Outpatient - Therapy Session <sup>2,3</sup>
- Marital/Family Therapy <sup>3</sup>
- Individual Outpatient - Speech Therapy <sup>1</sup>
- Group Outpatient - Group Therapy <sup>2,3</sup>
- Group Outpatient - Medication Maintenance
- Group Outpatient - Speech Therapy <sup>1</sup>

<sup>1</sup> Effective for dates of service on or after October 1, 1999, individual and group therapy are limited to four (4) units per day. One unit equals 15 minutes. Evaluations are limited to four (4) units per State Fiscal Year (July 1 through June 30). One unit equals 30 minutes. Extensions of the benefit limits will be provided if medically necessary for eligible Medicaid recipients under age 21.

<sup>2</sup> Effective April 1, 2000, these services require prior authorization for eligible Medicaid recipients age 21 and over to determine and verify the patient's need for services.

<sup>3</sup> Effective April 1, 2002, these services require prior authorization for eligible Medicaid recipients under age 21 to determine and verify the patient's need for services.

SUPERSEDES: TN- 01-15

|                            |   |
|----------------------------|---|
| STATE <u>Arkansas</u>      | A |
| DATE RECD <u>12-10-01</u>  |   |
| DATE APPVD <u>12-21-01</u> |   |
| DATE EFF <u>04-01-02</u>   |   |
| HCFA 179 <u>AR-01-35</u>   |   |

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT  
MEDICAL ASSISTANCE PROGRAM  
STATE ARKANSAS

ATTACHMENT 3.1-B  
Page 5e

AMOUNT, DURATION AND SCOPE OF  
SERVICES PROVIDED

Revised: April 1, 2002

MEDICALLY NEEDY

13. Other diagnostic, screening, preventive and rehabilitative services, i.e., other than those provided elsewhere in this plan. (Continued)

d. Rehabilitative Services (Continued)

1. Rehabilitative Services for Persons with Mental Illness (RSPMI) - (Continued)

b. Acute Day Treatment <sup>1</sup>

c. Restricted RSPMI Services

- Assessment-Reassessment and Plan of Care
- Crisis Stabilization Intervention <sup>1</sup>
- On-Site Intervention <sup>1,2</sup>
- Off-Site Intervention <sup>1,2</sup>
- Rehabilitation Day Services <sup>1,2</sup>

d. Other RSPMI Services

- Crisis Intervention
- Physical Examination
- Medication Maintenance by a Physician <sup>1</sup>
- Periodic Review of Plan of Care
- Routine Venipuncture for Collection of Specimen
- Catheterization for Collection of Specimen
- Collateral Intervention <sup>2</sup>
- Inpatient Visits in Acute Care Hospitals by Board Certified Psychiatrists

<sup>1</sup> Effective April 1, 2000, these services require prior authorization for eligible Medicaid recipients age 21 and over to determine and verify the patient's need for services.

<sup>2</sup> Effective April 1, 2002, these services require prior authorization for eligible Medicaid recipients under age 21 to determine and verify the patient's need for services.

SUPERSEDES: TN- 01-28

|                            |   |
|----------------------------|---|
| STATE <u>Arkansas</u>      | A |
| DATE REC'D <u>12-10-01</u> |   |
| DATE APP'D <u>12-21-01</u> |   |
| DATE EFF <u>04-01-02</u>   |   |
| HCFA 179 <u>AR-01-35</u>   |   |



**DEPARTMENT OF HEALTH & HUMAN SERVICES  
Centers for Medicare & Medicaid Services**

**Calvin G. Cline**

**Associate Regional Administrator, Medicaid and State Operations**

1301 Young Street, Room 827  
Dallas, Texas 75202  
Phone (214) 767-6301  
Fax (214) 767-0270

December 21, 2001

Our Reference: SPA-AR-01-35

Mr. Ray Hanley, Director  
Division of Medical Services – Slot 1103  
Arkansas Department of Human Services  
Post Office Box 1437  
Little Rock, Arkansas 72203-1437

Dear Mr. Hanley:

We have enclosed a copy of HCFA-179, Transmittal Number 01-35, dated November 30, 2001. This amendment requires prior authorization for outpatient mental health services for recipients under age 21.

We have approved the amendment for incorporation into the official Arkansas State Plan effective April 1, 2002. If you have any questions, please call Bill Brooks at (214) 767-4461.

Sincerely,

Calvin G. Cline  
Associate Regional Administrator  
Division of Medicaid and State Operations

Enclosure

cc: Elliott Weisman, CMSO



**ATTACHED LISTING FOR  
ARKANSAS STATE PLAN  
TRANSMITTAL #2001-035**

| <b>8. Number of the Plan<br/>Section or Attachment</b> | <b>9. Number of the Superseded Plan<br/>Section or Attachment</b> |
|--|---|
| Attachment 3.1-A, Page 1n                              | Attachment 3.1-A, Page 1n<br>Approved 12-14-92, TN 91-59          |
| Attachment 3.1-A, Page 1u                              | Attachment 3.1-A, Page 1u<br>Approved 03-26-01, TN 00-13          |
| Attachment 3.1-A, Page 1vvv                            | Attachment 3.1-A, Page 1vvv<br>Approved 08-31-01, TN 98-11        |
| Attachment 3.1-A, Page 1xxx                            | Attachment 3.1-A, Page 1xxx<br>Approved 05-14-01, TN 98-12;       |
| Attachment 3.1-A, Page 1xxxx                           | Attachment 3.1-A, Page 1xxxx<br>Approved 05-14-01, TN 98-12       |
| Attachment 3.1-A, Page 1yyy                            | Attachment 3.1-A, Page 1yyy <b>y</b> *                            |
| Attachment 3.1-A, Page 1yyyy                           | Attachment 3.1-A, Page 1yyyy <b>y</b> *                           |
| Attachment 3.1-A, Page 6a                              | Attachment 3.1-A, Page 6a<br>Approved 08-03-01, TN 01-15          |
| Attachment 3.1-A, Page 6b                              | Attachment 3.1-A, Page 6b<br>Approved 10-31-01, TN 01-28          |
| Attachment 3.1-B, Page 2m                              | Attachment 3.1-B, Page 2m<br>Approved 12-14-92, TN 91-59          |
| Attachment 3.1-B, Page 2t                              | Attachment 3.1-B, Page 2t<br>Approved 03-26-01, TN 00-13          |
| Attachment 3.1-B, Page 2tttt                           | Attachment 3.1-B, Page 2tttt<br>Approved 08-31-01, TN 98-11       |
| Attachment 3.1-B, Page 2vvv                            | Attachment 3.1-B, Page 2vvv<br>Approved 05-14-01, TN 98-12        |
| Attachment 3.1-B, Page 2vvvv                           | Attachment 3.1-B, Page 2vvvv<br>Approved 05-14-01, TN 98-12       |
| Attachment 3.1-B, Page 2wwww                           | Attachment 3.1-B, Page 2wwww<br>Approved 06-21-01, TN 01-17       |

Pen and ink change per Becky Murphy 12/21/01 E. Williams

**8. Number of the Plan  
Section or Attachment**

Attachment 3.1-B, Page 2wwwwww

Attachment 3.1-B, Page 5d

Attachment 3.1-B, Page 5e

**9. Number of the Superseded Plan  
Section or Attachment**

Attachment 3.1-B, Page 2wwwwww  
Approved 06-21-01, TN 01-17

Attachment 3.1-B, Page 5d  
Approved 08-03-01, TN 01-15

Attachment 3.1-B, Page 5e  
Approved 10-31-01, TN 01-28